

**South Carolina Department of Health and Human Services  
Electronic Funds Transfer (EFT) Authorization Agreement**

**PROVIDER INFORMATION**

Provider Name \_\_\_\_\_

Doing Business As Name (DBA) \_\_\_\_\_

Provider Address

Street \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

Zip Code/Postal Code \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_

Provider Federal Identification Number (TIN) or \_\_\_\_\_

Employer Identification Number (EIN) \_\_\_\_\_

Name on file with the IRS for the above TIN/EIN \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

**Provider EFT Contact Information**

Provider Contact Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Telephone Number Extension \_\_\_\_\_

Email Address \_\_\_\_\_

**FINANCIAL INSTITUTION INFORMATION**

Financial Institution Name \_\_\_\_\_

Financial Institution Address \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

Zip Code/Postal Code \_\_\_\_\_

Financial Institution Routing Number \_\_\_\_\_

Type of Account at Financial Institution (select one)

☐ Checking

☐ Savings

Provider's Account Number with Financial Institution \_\_\_\_\_

Account Number Linkage to Provider Identifier (select one)

☐ Provider Tax Identification Number (TIN)

☐ National Provider Identifier (NPI)

**REASON FOR SUBMISSION:**

☐ New Enrollment

☐ Change Enrollment

☐ Cancel Enrollment

By signing this form, I authorize the Department of Health and Human Services to initiate credit entries and to initiate, if necessary, debit entries for any credit entries in error to the checking or savings account indicated above at the financial institution identified above. Credit entries will pertain only to the Department of Health and Human Services payment obligations resulting from Medicaid services rendered by the provider. In the event of excess payment to this bank account, I authorize the Department of Health and Human Services to make an adjusting debit entry to the account up to the amount of the excess payment. Credit entries to the above account are done with the understanding that payment will be from federal and/or state funds and that any false claims, statements or documents or concealments of a material fact, may be prosecuted under applicable federal or state laws. I certify that the information shown is correct and agree to provide thirty (30) days written notice to the address shown below prior to revoking or revising this authorization.

☐ I acknowledge that I have read and understand that payments will be issued only to the bank account of the provider designated to receive payments beginning July 2019 with the transition of Medicaid claims payments to the South Carolina Enterprise Information System (SCEIS). For more information, please visit <https://vip.scdhhs.gov/sceis> or contact 888.289.0709. Providers' taxpayer identification numbers (either FEIN or SSN) and name must be validated with the Internal Revenue Service's (IRS) prior to SCDHHS issuing Medicaid claims payment. If providers' information fails IRS validation, providers are responsible for obtaining a confirmation letter from the IRS and providing this information to Provider Enrollment to correct the mismatch. Providers can request a confirmation letter by calling the IRS business & specialty tax line at 800-829-4933, 7a.m.-10.p.m., Monday-Friday. Please submit the IRS confirmation letter to Provider Enrollment with a subject line of "IRS Confirmation Letter" by scanning/emailing it to [Medicaid.Pets@bcbssc.com](mailto:Medicaid.Pets@bcbssc.com) or by fax at 803-264-5913. For questions or assistance, please call the Provider Service Center at 888-289-0709.

**All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any Medicaid direct deposits are made.**

Written Signature of Person Submitting Enrollment \_\_\_\_\_

Printed Name of Person Submitting Enrollment \_\_\_\_\_

Submission Date \_\_\_\_\_

**TO PROCESS YOUR EFT ENROLLMENT OR CHANGE EXISTING INFORMATION, PLEASE RETURN THIS COMPLETED FORM ALONG WITH VERIFICATION OF YOUR ELECTRONIC DEPOSIT INFORMATION ON YOUR FINANCIAL INSTITUTION'S LETTERHEAD TO:**

**Department of Health and Human Services, Medicaid Provider Enrollment • P.O. BOX 8809 • Columbia, South Carolina 29202-8809 • FAX (803) 870-9022**

**SPECIAL INSTRUCTIONS:** For questions regarding the status of your EFT enrollment, please contact the Provider Service Center at 1-888-289-0709. Please refer to the Electronic Funds Transfer (EFT) section of the Provider Enrollment manual found on the SCDHHS Provider web page for instructions on how to complete updates to your EFT information.

Effective January 01, 2014, providers have the capability to link their EFT payment transaction with their electronic remittance advice (ERA) via a matching EFT Reassociation Trace Number. This trace number will automatically be included in your SCDHHS electronic remittance advice. In order for this matching reassociation trace number to appear in your EFT notification, you must contact your financial institution and request the addition of this information. Any questions regarding this matching trace number and your ERA can be directed to the Provider Service Center at 1-888-289-0709.